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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Second Circuit

BRIEF *AMICI CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS AND THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF RESPONDENTS

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BRIEF *AMICI CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS AND THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICI CURIAE*

The Association of Private Pension and Welfare Plans ("APPWP") and The ERISA Industry Committee ("ERIC") submit this brief *amici curiae*, pursuant to Rule 37 of the Rules of this Court, with the consent of Petitioners and Respondents. Their letters of consent have been filed with the Clerk of the Court.

The APPWP is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this Nation's private employer-sponsored employee benefit plan system. The members of the APPWP include both small and large employer sponsors (including many Fortune 500 companies) of employee benefit plans, as well as numerous plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants. This broad-based membership provides the APPWP with substantial expertise and experience in the entire spectrum of issues relating to all types of benefit plans.

ERIC is a non-profit association committed to the advancement of employee retirement, health, and welfare benefit plans of the Nation's largest employers. All of ERIC's members do business in more than one state, and many have employees in all fifty states. The association has a strong interest in matters affecting its members' ability to deliver benefits, their cost and effectiveness, as well as the role of those benefits in the Nation's economy. The APPWP and ERIC have filed *amicus curiae* briefs in numerous cases involving important issues for the employee benefit plan community.

The outcome of this case will have a direct effect on the viability of the private employer-sponsored employee benefit plan system. The ability of employers to maintain and efficiently administer their employee benefit plans depends in large part on the absence of conflicting and bur-

densome state laws. Members of the APPWP and ERIC, as well as the entire private employer-based system of voluntarily providing health care coverage, will be affected adversely if the Court reverses the decision below, thereby narrowing the scope of the preemption provision in the Employee Retirement Income Security Act of 1974 ("ERISA").[1]

SUMMARY OF ARGUMENT

1. Surcharges on hospital rates imposed by the State of New York on some but not all third-party payors "relate to" ERISA plans because they are intended to, and they do, affect fundamental plan decisions with respect to health care coverage. The 13% surcharge imposed on all payors other than Blue Cross/Blue Shield (the "Blues"), Health Maintenance Organizations ("HMOs") and government plans such as Medicare, and the 11% surcharge on commercial insurers, are aimed at inducing ERISA plans to provide health care coverage to plan participants through a favored provider (*i.e.*, the Blues) rather than the panoply of other available options (*i.e.*, a wide range of commercial insurers or self-funding). Similarly, the surcharge of up to 9% imposed on HMOs based on the HMO's enrollment of Medicaid recipients discourages coverage through an HMO in favor of the Blues and encourages ERISA plans to select particular HMOs that are not subject to the surcharge. Each of the surcharges raises the cost of providing health care through ERISA plans unless such plans either tailor their administrative and funding structure to avoid the surcharges or reduce benefits to offset their increased costs. As laws that "relate to" ERISA plans, and that do not regulate insurance, the surcharges are preempted.

2. The Second Circuit's conclusion that ERISA preempts the hospital surcharges at issue does not prevent states from regulating public health and safety. Preemp-

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[1] Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988)).

tion of state-imposed marketplace incentives—such as the surcharges at issue here—that affect the structure of ERISA plans does not impinge upon legitimate exercises of states' traditional police powers.

ARGUMENT

I. THE SECOND CIRCUIT'S CONSTRUCTION OF SECTION 514(a) OF ERISA IS CONSISTENT WITH THE CONGRESSIONAL PURPOSE UNDERLYING ERISA PREEMPTION AND THIS COURT'S PRECEDENTS IN THIS AREA.

Applying preemption analysis to New York's hospital surcharges, the Second Circuit concluded:

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans.*

Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 719 (2d Cir. 1993) (emphasis added). This holding is consistent with both the congressional purpose underlying ERISA preemption and the precedents set by this Court.

A. The Purpose of ERISA Preemption Is to Eliminate State Interference in the Structure and Administration of ERISA Plans.

ERISA's framers sought a balance between encouraging a voluntary employer-based system and creating a regulatory framework for employee benefit plans. To avoid upsetting the careful balance that it sought, Con-

gress enacted a preemption provision that would encourage employers to maintain plans and expand coverage. Thus, ERISA's preemption provision was neither inadvertent nor casual. Rather, Congress intended ERISA's preemption provision, a provision that this Court has called "conspicuous for its breadth" (*FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990)), to provide national uniformity in the regulation of voluntary employer-sponsored plans.

Specifically, Congress provided in section 514(a) of ERISA that except as specified in certain narrow exceptions, ERISA preempts any state laws that "relate to" any ERISA plan. 29 U.S.C. § 1144(a) (1988). In language that is "deliberately expansive" (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987)), Congress recognized that a voluntary private employer-based system of providing benefits depends on federal preemption of state laws relating to ERISA plans.

The clear purpose behind ERISA's broad preemption provision was to eliminate conflicting and burdensome state regulation of ERISA plans:

> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, *which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.*

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987) (emphasis added). The Court's precedents consistently recognize the pivotal role of preemption in achieving the goal of uniformity in ERISA plan regulation. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142

(1990) (stating that "[s]ection 514(a) was intended to ensure that plans and plan sponsors woud be subject to a uniform body of benefits law" and that "[o]therwise, the inefficiencies created could work to the detriment of plan beneficiaries"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) (stating that "[b]y establishing benefit plan regulation 'as exclusively a federal concern,' Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees") (citation omitted).

The importance of preemption and national uniformity in ERISA plan regulation has never been more acute than it is now. Over 150 million Americans receive their health care coverage through voluntary employer-sponsored plans that are subject to ERISA. The ERISA plans of large multistate employers are not designed with the parochial requirements of a particular state in mind; they are designed to provide a uniform system of benefits for the employer's workforce. Indeed, even many small employers with facilities in a single state sponsor plans that cover employees who reside in different states. ERISA, through its broad preemption provision, makes it possible for employers of all sizes to maintain health benefit plans under a single administrative and design structure regardless of where they do business or the number of states in which their employees reside. This uniformity in the benefits provided to plan participants and beneficiaries yields significant savings in administrative expenses, reduces the contributions that employees and employers must make to their benefit plans, and enables employers to devote a higher percentage of their benefit budget to providing benefits rather than paying plan expenses.

Sky-rocketing health care costs already subject ERISA plans to severe economic strain, challenging the most innovative employers to explore and develop cost-effective programs to serve the needs of plan participants while

minimizing plan administrative burdens. In the face of existing cost escalation, it would be no small task to also attempt to comply with inconsistent and burdensome state regulations that interfere with fundamental plan design issues—such as the selection of a service provider. ERISA already imposes significant administrative responsibilities on a plan sponsor through its reporting and disclosure requirements. The multiple tasks that would be created if each of the fifty states mandates a "different plan" would impose staggering obligations that Congress foresaw and rejected.

B. A State Law Relates to an ERISA Plan if It Affects Plan Choices with Respect to Plan Design.

In order for preemption to apply, a state law must "relate to" ERISA plans. 29 U.S.C. § 1144(a). A state law "relate[s] to" ERISA plans if it " 'has a connection with or reference to such a plan.' " *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The Second Circuit correctly concluded that state laws which affect plan design decisions fall within the scope of section 514(a) of ERISA.

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), establishes that state laws which affect plan design decisions "relate to" ERISA plans. In *Metropolitan Life*, the Court considered whether ERISA preempted a Massachusetts mandated benefit law that required group health insurance policies to include specified mental health benefits. The Court had little difficulty concluding that the Massachusetts law related to ERISA plans:

> Though § 47B [the relevant statutory provision] is not denominated a benefit-plan law, it bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy. . . . we

> agree . . . that the mandated-benefit law as applied relates to ERISA plans and thus is covered by ERISA's broad pre-emption provision set forth in § 514(a).

Id. at 739. Thus, the Court recognized that state laws affecting a plan sponsor's fundamental decisions about which benefits will be provided and how they will be provided under the plan "relate to" ERISA plans.

C. New York's Hospital Surcharges Relate to ERISA Plans Because They Affect Plan Design.

New York's regulatory scheme with respect to hospital rates has several components, two of which are relevant here. First, New York Public Health Law § 2807-c(1)(a) directs hospitals to charge for in-patient services on the basis of classifications of hospital discharges known as diagnosis-related groups (DRGs) as opposed to actual charges. This aspect of New York's regulation of hospital rates applies uniformly to all third-party payors, including all ERISA plans and is not challenged here. A second component of New York's regulatory scheme, the surcharges that are at issue, apply selectively to certain third-party payors. Specifically, the 13% surcharge above the DRG rate set forth in New York Public Health Law § 2807-c(1)(b) applies when a patient is covered by an employer's ERISA plan whether insured through commercial insurance or self-insured, or by any other form of health plan, except for patients covered by the Blues, an HMO or government plans like Medicare. The surcharge set forth in New York Public Health Law § 2807-c(11)(i) imposed an additional 11% surcharge above the DRG rate on payments made by commercial insurers.[2] Finally, a third surcharge of up to 9% above the DRG rate applies only to HMOs based on the HMO's enroll-

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[2] The 11% surcharge applied for the period April 1, 1992 through March 31, 1993. N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney's Supp. 1995).

ment of Medicaid recipients. N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney's Supp. 1995).

The hospital surcharges are state-imposed marketplace incentives that are directed at affecting plan design. *See* Brief for the United States as *Amicus Curiae* Supporting Petitioners at 18 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415). The 13% and 11% surcharges aim at inducing health plans, including ERISA plans, to subscribe to the Blues. *Travelers Ins. Co. v. Cuomo*, 14 F.3d at 712. Conversely, these surcharges discourage ERISA plans from providing health care coverage to participants through self-insurance or through policies with commercial insurers. While the HMO surcharge on its face encourages HMOs to enroll individuals who are eligible for Medicaid in order to avoid the 9% surcharge, it also makes HMOs a more expensive coverage alternative relative to the Blues. In addition, it induces health plans, including ERISA plans, that decide nonetheless to offer an HMO coverage option to select HMOs that are exempt from the surcharge. In each case, the surcharges affect fundamental decisions made by an ERISA plan about the method of providing coverage to plan participants and beneficiaries, *i.e.*, whether to self-insure, to obtain insurance from a commercial carrier, or to provide coverage through the method favored in the New York hospital surcharge laws.[8]

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[8] The Secretary of Labor recognized this result in its brief as *amicus curiae* in the Second Circuit: "The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge." Brief for the Secretary of Labor as *Amicus Curiae* in the Second Circuit at 20 (filed Mar. 17, 1993) (Nos. 93-7134, 7148).

The hospital surcharges expose ERISA plans to additional costs[4] that can be avoided only by altering plan design and structure in New York. Indeed, if each state is permitted to enact laws of this type, ERISA plans will be forced to tailor their fundamental structure for providing benefits to comport with incentives imposed by each of the different states in which plan participants receive hospital services. For example, New York's market incentives favor coverage through the Blues, but another state may use its hospital rates to reflect different incentives (for example, self-insurance or insurance through commercial carriers that cover certain experimental treatments). Because states are likely to design incentives that are flatly inconsistent with each other, a plan sponsor would have to establish separate plans for each jurisdiction in which plan participants are likely to receive hospital services. The clear purpose of ERISA preemption is to shield ERISA plans from precisely this type of state interference in plan design.

The assertion that the hospital surcharges do not "impose obligations upon plan conduct" (Brief for Petitioners Mario M. Cuomo, *et al.* at 27 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415)) is not dispositive of whether the surcharges "relate to" ERISA plans. On the contrary, the Court's precedents recognize that the policy of uniformity requires an interpretation of section 514(a) of ERISA that is not limited to state laws that purport to regulate plan terms and conditions. *Ingersoll-Rand*, 498 U.S. at 141-42 (expressly rejecting an argument that section 514(a) preempts only state laws that affect plan terms or conditions); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988) (holding that

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[4] The record below establishes that commercial insurance carriers will pass the surcharges along to their ERISA plan customers. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996, 1003 (S.D.N.Y.), *aff'd in part and rev'd in part*, 14 F.3d 708 (1993). Of course, the 13% surcharge applies directly to third-party payors that are self-funded ERISA plans.

ERISA preempts a state garnishment law that excluded ERISA plan benefits from garnishment and that did not affect any plan terms or conditions). For example, *Ingersoll-Rand* considered whether ERISA preempted a state law cause of action for wrongful discharge based on an employer's desire to avoid paying benefits due under an ERISA plan. In holding that the state law cause of action was preempted, the Court wrote:

> Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a). . . . It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Ingersoll-Rand, 498 U.S. at 142. The same problem that the Court recognized in *Ingersoll-Rand* in the context of state law causes of action arises if state legislatures are allowed to impose different market-based incentives and penalties to a plan sponsor's decisions with respect to the method of providing health insurance coverage. The resulting patchwork system would require employer plan sponsors to tailor their plans and their conduct to the market preferences of the legislatures of each jurisdiction. This result is inconsistent with the Congressional purpose underlying ERISA preemption and is precisely the outcome that Congress sought to avoid.[5] There is no doubt that this

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[5] The Second Circuit correctly concluded that the hospital surcharges are not saved from preemption under section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) (1988), as laws that regulate insurance. *Amici* believe that the savings clause issue of section 514(b)(2)(A) is adequately addressed in the briefs of Respondents. Accordingly, this brief *amici curiae* does not repeat analysis of why the hospital surcharges do not constitute laws regulating insurance.

Court would strike down a state law that imposed a higher tax on a plan that failed to cover mental illness than on a plan that provided such coverage. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The New York laws imposing hospital surcharges are no less intrusive and, if allowed to stand, will lead to no different result.

II. THE SECOND CIRCUIT'S DECISION DOES NOT PREVENT STATES FROM REGULATING PUBLIC HEALTH AND SAFETY.

Amici National Governors' Association, *et al.*, attempt to characterize New York's hospital rate regulations as legitimate exercise of a state's power to regulate public health and safety. *See* Brief of the National Governors' Association *et al.*, as *Amici Curiae* in Support of Petitioners at 11 (filed Nov. 13, 1994) (Nos. 93-1408, 93-1414, 93-1415). In support of this proposition, *amici* cite *Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707 (1985). *Hillsborough* analyzed whether local regulations affecting plasma donors and collected plasma were preempted by regulations of the Food and Drug Administration. The regulations at issue here, unlike those at issue in *Hillsborough*, are not the kind of public health regulations that fall within a state's exercise of its police powers. The surcharges are regulations that affect the health care marketplace, not health care generally. They aim at making certain kinds of coverage less competitive than others. *Travelers Ins. Co. v. Cuomo*, 14 14 F.3d at 712. Certain quality control regulations, like those at issue in *Hillsborough* or regulations with respect to sanitary standards for hospitals and disposal of medical wastes (*see* Brief of Petitioners Mario M. Cuomo, *et al.*, at 24 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415) and *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, 1196 (3d Cir.), *cert. denied*, 114 S. Ct. 383 (1993)), can be characterized legitimately as exercises

of a state's traditional police powers. State regulations that impose market incentives with respect to different types of health care coverage are not susceptible to such characterization.

It is important to note that this case does not present the issue of whether it is permissible for states to require hospitals to load DRG rates to reflect uncompensated care costs thereby shifting such costs to ERISA plans directly (in the case of self-funded plans) or indirectly (in the case of ERISA plans that provide insurance coverage through commercial insurance or other third-party payors). The New York surcharges represent market incentives that are designed to affect the decisions ERISA plans make with respect to the source of health insurance coverage. As such, the surcharges affect plan design and consequently relate to ERISA plans.

CONCLUSION

For the reasons stated above, this Court should affirm the Second Circuit's decision below.

Respectfully submitted,

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